

2. Facility classification changes shall only be recognized at the time of a Rebasing. If a facility changes classification in accordance with the definitions above, then rates established under this Plan shall continue to apply until the Rebasing. A facility that adds an approved intern and resident teaching program, however, may seek rate reconsideration under Section V.C.1.c.

C. SERVICE CATEGORY DESIGNATIONS

1. Services provided by acute inpatient facilities shall be classified into four mutually exclusive categories:
  - a. Maternity - An inpatient stay which results in a delivery with a maternity principal or secondary diagnosis code;
  - b. Surgical - An inpatient stay with the following characteristics:
    - (1) the claim has not been classified as a maternity claim;
    - (2) the claim includes a surgical code that is considered to be an operating room procedure in the latest and most current version of the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM); and
    - (3) the claim includes either:
      - (a) a surgical date; or
      - (b) an operating room charge.
  - c. Psychiatric - An inpatient stay with a primary psychiatric principal diagnosis code and with no operating room charge; or
  - d. Medical - An inpatient stay not classified into one of the above three service categories.

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D. PREPARATION OF DATA FOR CALCULATION OF BASE YEAR

PROSPECTIVE PAYMENT RATES

1. Base Year Claim Charge Data shall be prepared in order to establish charge ratios used in the payment calculation.
  - a. Claim Charge Data for all Medicaid claims shall be considered based on dates of discharge which correspond to each facility's fiscal year end. Medicare cross-over claims shall be excluded from the calculation.
  - b. If more than one year of Claim Charge Data is used, the charges reflected on the earlier year's claims data shall be inflated to the period covered by the most recent year's claims data in accordance with Section II.A.3.
  - c. Claims shall be edited and properly classified.
  - d. Claim Charge Data, including charge amounts, days of care, and number of discharges, shall be classified into the four service categories identified in Section II.C.1. Combined claims for the delivery of a normal newborn shall be counted as one discharge in the calculation process. Claims for newborns described in Section III.E.1.e shall be classified into the appropriate service category.
  - e. Claim charge data for surgical, maternity, and medical claims in Classification II and III facilities shall be segregated into routine, special care, and ancillary service charges. Nursery charges shall be included in the routine charges.
  - f. Claim Charge Data shall be adjusted in the case of Classification II and III facilities to delete nonpsychiatric ancillary claim charges associated with claims in excess of

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the Outlier Threshold in effect for the Base Year.

- g. Claim Charge Data shall be adjusted to delete ancillary charges for wait listed patients.
2. Cost report data, including costs, days, and discharges, shall be extracted from Base Year cost reports and shall be prepared in order to determine Medicaid allowable inpatient facility costs.
- a. Cost of services excluded under Section I.E. shall be deleted from costs for purposes of the prospective rate calculation. This process shall involve identifying items pertaining to the excluded services and subtracting these costs from the cost report data.
  - b. Costs in excess of federal Medicare cost reimbursement limitations shall be deleted from costs for purposes of the prospective rate calculation. Costs which are not otherwise specifically addressed in this plan shall be included in a Base Year if they comply with HCFA Publication 15 standards. Capital costs associated with the revaluation of assets for any reason or due to a change in ownership, operator, or leaseholder where such revaluation occurred after July 18, 1984 shall be identified and excluded. Costs in excess of charges shall not be deleted from costs for the purpose of the prospective rate calculation.
  - c. Allowable Medicaid inpatient facility costs shall be determined separately for routine and ancillary costs. Nursery costs shall be combined with other routine costs and reclassified into the routine service component.
  - d. The Medicaid inpatient portion of malpractice costs shall be determined by multiplying the ratio of Medicaid inpatient costs to total costs by the facility's total malpractice

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costs. This amount shall be added to allowable Medicaid inpatient facility costs.

- e. To recognize costs differences due to varying fiscal year ends and annual inflationary increases, allowable Medicaid inpatient facility costs shall be standardized and inflated as described in Section III.G.
- f. Capital, medical education, and for Proprietary Providers, return on equity and gross excise tax amounts, shall be deleted from allowable Medicaid inpatient facility costs and shall be reimbursed in accordance with Section III.D.
- g. Except as stated in Section I.E., services provided to patients during an inpatient stay but billed by a provider other than the inpatient facility shall be added to allowable Medicaid inpatient facility costs. To obtain the estimated amount, the Department shall survey facilities and accept reasonable estimates of such services.
- h. In computing the nonpsychiatric ancillary per discharge rates, the total ancillary costs and discharges associated with nonpsychiatric outlier claims and the ancillary costs associated with wait listed patients shall be deleted from allowable Medicaid inpatient facility costs and discharges based on the claim charge ratios identified in Section II.D.1. above. Routine costs and days related to the outlier claims shall be included in inpatient costs and days extracted from the costs reports and used in computation in the prospective payment rates. Routine costs and days related to wait listed patients shall not be extracted from the cost reports and shall be excluded from the computation of the inpatient rates.

### III. CALCULATION OF BASE YEAR PROSPECTIVE PAYMENT RATES

#### A. PSYCHIATRIC SERVICES

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1. A base per diem rate for acute psychiatric inpatient services shall be established for all inpatient facilities using the following general methodology:
  - a. Deduct the Capital Related Costs allocated to psychiatric services on the Base Year cost report.
  - b. Establish facility-specific ratios from Claim Charge Data for psychiatric routine, special care, and ancillary charges and days to total routine, special care, and ancillary charges and days.
  - c. Multiply the ratios in paragraph (b), by total Medicaid inpatient costs, excluding Capital Related Costs and days for routine, special care, and ancillary to achieve total psychiatric routine, special care, and ancillary Medicaid inpatient costs and days as derived from the cost report.
  - d. Sum the resulting psychiatric costs and days for routine, special care, and ancillary and achieve a facility-specific average Medicaid psychiatric cost per day by dividing total psychiatric Medicaid inpatient cost by total psychiatric inpatient Medicaid days.
2. A psychiatric per diem rate ceiling which applies to all facilities statewide shall be calculated in the following manner:
  - a. Total the costs, excluding Capital Related Costs, and days for all psychiatric services for all facilities, as identified in (1). Any per diem amount that is greater than two standard deviations above or below the statewide mean shall be excluded in calculating the component rate ceilings;
  - b. Divide the total psychiatric inpatient costs calculated in paragraph (a) by total psychiatric inpatient days; and

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- c. Multiply the result of paragraph (b) by the statewide psychiatric ceiling factor of 1.15. This result shall be the statewide Base Year per diem rate ceiling for psychiatric services.
3. The prospective payment rate for psychiatric services for all facilities shall equal the lesser of either the facility-specific per diem rate or the per diem rate ceiling for inpatient psychiatric services.

B. CLASSIFICATION I - NONPSYCHIATRIC SERVICES

1. A base per diem rate for nonpsychiatric services for Classification I facilities shall be established using the following general methodology:
  - a. Deduct the Capital Related Costs allocated to nonpsychiatric services on the Base Year cost report.
  - b. Calculate nonpsychiatric inpatient Medicaid facility costs and days for all facilities in Classification I by subtracting the facility's psychiatric costs and days for routine, special care, and ancillary services as specified in Section III.A. from the facility's total allowable Medicaid inpatient costs and days for routine, special care, and ancillary services as derived from the cost report and as calculated in Section II.D.
  - c. Sum the resulting costs, excluding Capital Related Costs, and days for routine, special care, and ancillary services and achieve a facility-specific Medicaid inpatient nonpsychiatric cost per day by dividing total nonpsychiatric Medicaid costs by total nonpsychiatric inpatient Medicaid days. Any per diem amount that is greater than two standard deviations above or below the statewide mean shall be excluded in calculating the component rate ceilings;

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2. The Classification I per diem rate ceiling for nonpsychiatric services shall be calculated as follows:
  - a. Total the costs, excluding Capital Related Costs, and days for all nonpsychiatric services for all facilities in Classification I, as identified in (1). Any per diem amount that is greater than two standard deviations above or below the statewide mean shall be excluded in calculating the component rate ceilings;
  - b. Divide total nonpsychiatric inpatient costs calculated in paragraph (a) by total nonpsychiatric inpatient days for all facilities in Classification I; and
  - c. Multiply the result of paragraph (b) by the nonpsychiatric Classification I ceiling factor of 1.20. This result shall be the Classification I per diem rate ceiling for nonpsychiatric facilities.
3. The prospective payment rate for Classification I facilities shall equal the lesser of either the facility-specific per diem rates or the Classification I per diem rate ceiling for nonpsychiatric inpatient services.

C. CLASSIFICATIONS II AND III - NONPSYCHIATRIC SERVICES

1. The facility-specific prospective payment base rates for nonpsychiatric services rendered in facilities in Classifications II and III shall be comprised of two separately established rate components, one per diem rate for routine services and one per discharge rate for ancillary services.
2. The facility-specific base routine per diem and per discharge ancillary rate for nonpsychiatric services for each service category (maternity, surgical and medical) shall be established using the following general methodology:

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- a. Deduct the Capital Related Costs allocated to nonpsychiatric services and ancillaries on the Base Year cost report.
  - b. Determine separately for each service category the ratio of nonpsychiatric claim charges, days, and discharges to total claim charges, days, and discharges associated with routine, special care, and ancillary components.
  - c. Multiply the ratios determine in (b) by total Medicaid inpatient days, discharges and costs, excluding Capital Related Costs.
  - d. Determine the routine per diem costs for each service category by dividing the sum of routine and special care costs, excluding Capital Related Costs, by the sum of routine and special care days as derived from the cost report.
  - e. Determine the facility ancillary cost per discharge for each service category by dividing the ancillary service costs, excluding Capital Related Costs, by the discharges as derived from the cost report.
3. The Base Year per diem rate component ceiling shall be calculated for each nonpsychiatric service category for all facilities in Classifications II and III as follows:
- a. For all facilities within a classification, total for each service category the routine costs, excluding Capital Related Costs, and days identified in (2). Any per diem amount that is greater than two standard deviations above or below the statewide mean shall be excluded in calculating the component rate ceilings;
  - b. Divide the total costs calculated in paragraph (a) above for each service category by the total patient days;

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- c. Multiply the result for each facility classification by the nonpsychiatric Classification II and III ceiling factor of 1.20; and
  - d. The result shall be the per diem rate component ceiling for nonpsychiatric services for each service category within each facility classification.
4. A facility's prospective payment rate component for routine services for each nonpsychiatric service category shall equal the lesser of either the facility-specific base rate component or the per diem rate ceiling for the appropriate facility classification.
5. The ancillary services per discharge rate component ceiling shall be established separately for each service category in the following manner:
  - a. For all facilities within a classification, total the ancillary costs, excluding Capital Related Costs, and discharges within each nonpsychiatric service category. Any average per discharge amount that is greater than two standard deviations above or below the statewide mean shall be excluded in calculating the component rate ceilings;
  - b. Divide the total costs calculated in paragraph (a) above by total discharges for each service category;
  - c. Multiply the result of paragraph (b) for each facility classification by the nonpsychiatric Classification II and III ceiling factor of 1.20; and
  - d. The result shall be the ancillary rate component ceiling for nonpsychiatric services for each nonpsychiatric service category within each facility classification.
6. A facility's prospective per discharge base payment rate component for ancillary services for each nonpsychiatric service category shall equal

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the lesser of either the facility-specific per discharge base rate or the per discharge rate ceiling for the appropriate facility classification.

D. ADDITION OF FACILITY-SPECIFIC FACTORS

1. A facility's Basic Per Diem and Per Discharge Rates, as determined above, shall be adjusted to recognize factors that are specific to that Provider. Those adjustments may include the Medical Education Adjustment and/or the ROE/GET Adjustment. Eligible Providers shall also receive payments in addition to the Basic Per Diem and Per Discharge Rates (e.g., Capital Payments).
2. The Capital Payments shall be determined and paid as follows:
  - a. The interim Capital Payments shall be determined according to the general procedures that are used to reimburse hospitals that are exempt from the Federal PPS for capital costs under Medicare (and prior to the implementation of the Medicare capital PPS), except that Capital Related Costs shall be reduced by 10%. At the option of the Department, the following procedure may be utilized:
    - (1) Each facility shall identify its Capital Related Costs associated with providing acute care services. If a facility provides both acute and distinct part long term care services, only the Capital Related Costs associated with acute care shall be identified.
    - (2) Each facility shall submit an estimate of its allowable Capital Related Costs and projected Medicaid utilization for each PPS rate year. The projected Medicaid utilization shall be based upon the ratio of Medicaid patient days to total patient days.

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